

4088

CERTIFICATE OF DEATH

Reg. Dist. No.

166

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b> c. LENGTH OF STAY IN 1b <b>3 mo.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cuppett Nursing Home</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park, Md. X</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary McRobie Brooks</b>				4. DATE OF DEATH Month Day Year <b>April 16, 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 10, 1880</b>	
9. AGE (In years last birthday) <b>76 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Swanton, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Francis M. McRobie</b>			
14. MOTHER'S MAIDEN NAME <b>Lucy McRobie</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <b>Mrs. Lee Lucas, Bayard, W. Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>March 15, 1957</b> to <b>April 16, 1957</b> , that I last saw the deceased alive on <b>April 15, 1957</b> , and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. I. Baumgardner</b> M.D.				ADDRESS (Street, city or town, state) <b>Deer Park, Md.</b> DATE SIGNED <b>4/10/57</b>			
PHYSICIAN'S NAME (Type) <b>E. I. BAUMGARDNER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 20, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Deer Park</b>		22d. LOCATION (City, town, or county) (State) <b>Deer Park, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bolden Funeral Home</b> ADDRESS <b>Oakland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>4/20/57</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Brown</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

See how the

DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

BUREAU V. S.

APR 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4989 CERTIFICATE OF DEATH

Reg. Dist. No. 040926

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) b. COUNTY <b>GARRETT</b> MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DEER PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DEER PARK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>SAMUEL S. BROWNING</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>13</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 4, 1870</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED PAINTER</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GREENGLADE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ARCHIBALD BROWNING</b>	
14. MOTHER'S MAIDEN NAME <b>KATHRYN FRAZEE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. VAN BROWNING</b> Address <b>DEER PARK, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>10 years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>April</b> Day <b>13</b> Year <b>1957</b> Hour <b>11:20</b> a.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 10, 1957</b> , to <b>April 13, 1957</b> , that I last saw the deceased alive on <b>April 13, 1957</b> , and that death occurred at <b>11:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak Street</b> DATE SIGNED <b>April 15, 1957</b>	
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton</b>		<b>Oakland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/16/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>DEER PARK</b>	22d. LOCATION (City, town, or county) (State) <b>DEER PARK MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>BOLDEN</b>		24. RECEIVED BY REGISTRAR DATE <b>4/16/57</b>	
ADDRESS <b>OAKLAND MD.</b>		24b. REGISTRAR'S SIGNATURE <b>John T. Hagan</b>	

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. 3

APR 18 1957

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04094

4090

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Selbysport</u>		<u>Lifetime</u>		TOWN <u>Selbysport</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Inez</u> (Middle) <u>Mae</u> (Last) <u>Friend</u>				(Month) <u>4</u> (Day) <u>4</u> (Year) <u>19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>4/16/1878</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Keeper</u>		<u>Own Home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Winfield Scott Friend</u>				<u>Eva Ellen Laughrey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Miss. Agnes Frazee, Selbysport</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450.0 IMMEDIATE CAUSE (A) <u>Arterio Sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Rheumatic Deformers</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senility</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1950</u> , 19 <u>57</u> to <u>Apr 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Apr 30</u> , 19 <u>57</u> , and that death occurred at <u>11:30 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>H. B. Messmore</u>				DATE SIGNED <u>Apr 4 - 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/7/1957</u>		<u>Friendsville</u>		<u>Friendsville Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>April 6, 1957</u>		<u>Mr Ruth Freutz Op</u>		<u>Jack S. Friend, Friendsville</u>			

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

24942  
24942

BUREAU V. 3

1957 9 MAY 10

RECEIVED  
HARRISON  
MAY 10 1957

M. B. Harrison  
May 30 57

4091

## CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Oakland</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Oakland Xo</b>			
				d. STREET ADDRESS <b>1</b>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Catherine</b> <b>Georg</b>				4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 30, 1878</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Accident, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Christian Bietzel</b>				14. MOTHER'S MAIDEN NAME <b>Susan Bowman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Fred Glotfelty, Oakland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C-V Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>?</b> DUE TO (c) <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12 Nov. 1945</b> to <b>28 April 1957</b> , that I last saw the deceased alive on <b>26 April 1957</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Oakland Md</b> DATE SIGNED <b>28 April 57</b> ACTUAL SIGNATURE <b>A. E. Mance</b> M.D. <b>Oakland, Maryland</b> PHYSICIAN'S NAME (Type) <b>A. E. Mance, M. D.</b> <b>Oakland, Maryland</b> <b>28 April, '57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 1, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Accident</b>		22d. LOCATION (City, town, or county) (State) <b>Accident Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bolden Funeral Home</b> <b>Oakland, Md.</b>				24a. REC'D BY REGISTRAR <b>5/1/57</b>		24b. REGISTRAR'S SIGNATURE <b>Julius E. Brown</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1. Name of deceased: *Walter Andrew*

RECEIVED

MAY 3 1957

BUREAU V. S.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04097

## 4092 CERTIFICATE OF DEATH

Item 13 Film G213 4-12-57 et

Reg. Dist. No. 172

1. PLACE OF DEATH COUNTY GARRETT CITY (If outside corporate limits, write RURAL OR TOWN) KITZMILLER HOSPITAL OR INSTITUTION OR STREET ADDRESS OAK STREET				2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY GARRETT CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KITZMILLER STREET ADDRESS OAK STREET			
3. NAME OF DECEASED (Type or Print) (First) SAMUEL (Middle) ALONZO (Last) HADDIX				4. DATE OF DEATH (Month) (Day) (Year) APRIL 2, 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB. 22, 1869	9. AGE last birthday 88 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER			10b. KIND OF BUSINESS OR INDUSTRY COAL MINES		11. BIRTHPLACE (State or foreign country) Grafton, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Adam Haddix				14. MOTHER'S MAIDEN NAME JULIA ANN KERNS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Mrs. Annie Haddix, Kitzmiller, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Acute Myocarditis ANTECEDENT CAUSE(S) DUE TO Coronary Heart Disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pernicious Anemia						4 days 5 1/2 hrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 4, 1957, to April 2, 1957, that I last saw the deceased alive on April 2, 1957, and that death occurred at 10:45 AM from the causes and on the date stated above.							
SIGNATURE M. D. Kitzmiller Md		ADDRESS (Street, city, town, state) Blaine, W. Va.		DATE SIGNED April 2-57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/5 /57		NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		LOCATION (City, town, or county) (State) Elk Garden, W.Va.	
24. REC'D BY REGISTRAR DATE 4/4/57		REGISTRAR'S SIGNATURE A. W. Barwick		25. FUNERAL DIRECTOR'S SIGNATURE O. J. Sparkless		ADDRESS Blaine, W. Va.	

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is faint and mostly illegible.

BUREAU V. 8.

APR 8 1957

RECEIVED

RECEIVED  
APR 10 1957  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C.

4093

CERTIFICATE OF DEATH

Reg. Dist. No. 166

01092

1. PLACE OF DEATH o. COUNTY <b>GARRETT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND MD</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WEEKS NURSING HOME</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>FRANKLIN KIMMELL</b>				4. DATE OF DEATH <b>APRIL 7 1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB-22-1886</b>		9. AGE (In years last birthday) <b>71</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>THAYERVILLE</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>	
13. FATHER'S NAME <b>WILLIAM KIMMELL</b>				14. MOTHER'S MAIDEN NAME <b>JENNY BOWSER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>CLAUDE KIMMELL CUMBERLAND MD</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA of STOMACH</b> <b>151X 0.5 cm DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute ulcerative</b> (c) <b>Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4200</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>1-1-1957</b> to <b>7-6-1957</b> , that I last saw the deceased alive on <b>4-6-1957</b> , and that death occurred at <b>12:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5821 St. Oakl. Md.</b> DATE SIGNED <b>4.8.57</b>							
ACTUAL SIGNATURE <b>[Signature]</b>				PHYSICIAN'S NAME (Type) <b>[Signature]</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>APRIL-9-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>THAYERVILLE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>THAYERVILLE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>				24a. REC'D BY REGISTRAR <b>[Signature]</b> 24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			
ADDRESS <b>OAKLAND MD</b>				DATE <b>4/9/57</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 11 1967

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04101  
166

4094

1 PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL GORMANIA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS ROUTE #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMA		First Middle Last MAY MARTIN		4. DATE OF DEATH		Month Day Year APRIL 18 19 57	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/2/96	
9. AGE (In years lost birthday) 61 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BARTON, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANK KYLE		14. MOTHER'S MAIDEN NAME ANNA MAY LEE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT CARL C. ATHEY? Box 1 25, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4.1.1 DUE TO Anterograde & degenerative C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6 Apr 1957 to 4/18/1957, that I last saw the deceased alive on 4/18/1957, and that death occurred at 9:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Oakland Md 18 Apr 57			
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M. D.				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/21/57		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill		22d. LOCATION (City, town, or county) (State) MOSCOW, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bolden Funeral Home				ADDRESS: Oakland, Md.		24a. REC'D BY REGISTRAR DATE 4/19/57	
				24b. REGISTRAR'S SIGNATURE			

RECEIVED

APR 30 1957

BUREAU V. S.

1

INSTRUCTIONS

**1** hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO ATTENDING PHYSICIAN:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**VS AISC 1-55 10M**

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04102

## CERTIFICATE OF DEATH

4995

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>W. Va.</u>		COUNTY <u>Mongalia</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Friendsville</u>		<u>3 years</u>		OR TOWN <u>Near Morgantown</u>		<u>112-1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Malissie</u> (Middle) <u>Rachel</u> (Last) <u>McCartney</u>				(Month) <u>4</u> (Day) <u>22</u> (Year) <u>19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>June 30, 1879</u>	<u>77</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housekeeper</u>		<u>Own Home</u>		<u>West Virginia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Scott Dobbins</u>				<u>Katherine Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>							
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				<u>Coronary occlusion</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Arteriosclerotic Heart Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>Thrombophlebitis left leg - 2 months</u>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from <u>1954</u> , 19 <u>1954</u> , to <u>April 16, 1957</u> , that I last saw the deceased alive on <u>April 16, 1957</u> , and that death occurred at <u>12th</u> , from the causes and on the date stated above.							
SIGNATURE <u>Harold Okamoto</u>				ADDRESS (Street, city, town, state) <u>R.D. Markleysburg, Pa.</u>			
DATE <u>April 22, 1957</u>				DATE SIGNED <u>57</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>4/24/57</u>		<u>Hallack Cemetery</u>		<u>Nr. Morgantown, W. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>April 22, 1957 Mrs. Ruth Thrall</u>		<u>Jack A. Lee of Friendsville</u>					

BUREAU V. S.

APR 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4996 CERTIFICATE OF DEATH

Reg. Dist. No. 186

041103

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. LENGTH OF STAY IN 1b <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crellin</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>				d. STREET ADDRESS <b>Box 42</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Oscar</b> Middle <b>Adam</b> Last <b>Shaffer</b>				4. DATE OF DEATH Month <b>4</b> Day <b>19</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-1-1885</b>	
9. AGE (In years last birthday) <b>72</b> yrs		IF UNDER 1 YEAR Months <b>19</b> Days <b>15</b> Hours <b>57</b>		IF UNDER 24 HRS. Hours <b>19</b> Minutes <b>57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Shaffer, Daniel</b>				14. MOTHER'S MAIDEN NAME <b>Saucer, Ellen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-10-4753</b>		17. INFORMANT Address <b>"Gladys Graham Shaffer (Wife) Box 42, Crellin, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspirin</b> DUE TO <b>Carcinoma Lung Bilateral</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>6 Days</b> (c) <b>6 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19</b> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10/22, 1945</b> , to <b>19 Apr 1957</b> , that I last saw the deceased alive on <b>19 Apr 1957</b> , and that death occurred at <b>4:40 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Andrew E. Mance</b> M.D.				ADDRESS (Street, city or town, state) <b>Oakland Md</b> DATE SIGNED <b>20 Apr 57</b>			
PHYSICIAN'S NAME (Type) <b>ANDREW E. MANCE</b> M.D.				<b>OAKLAND MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/22/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bolden</b> ADDRESS <b>Bolden Funeral Home Oakland, Md.</b>				24a. REG'D BY REGISTRAR <b>4/22/57</b> DATE		24b. REGISTRAR'S SIGNATURE <b>John G. Brown</b>	

272

RECEIVED

APR 20 1957

BUREAU V. S.

4097

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park,</b>		c. LENGTH OF STAY IN 1b <b>16 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Missouri</b> Middle <b>Belle</b> Last <b>Speicher</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1866</b>
9. AGE (in years last birthday) <b>90</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William m Nln e</b>		14. MOTHER'S MAIDEN NAME <b>Artheia Shaw</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Harry Speicher</b>		Address <b>Deer Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>4300.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>15 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 13</b> , 1948, to <b>April 29</b> , 1957, that I last saw the deceased alive on <b>April 29</b> , 1957, and that death occurred at <b>8:30 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andrew E. Mance</b> M.D.		ADDRESS (Street, city or town, state) <b>Oakland, Md.</b> DATE SIGNED <b>30 Apr 57</b>	
PHYSICIAN'S NAME (Type) <b>A. E. Mance, M. D.</b>		<b>Oakland, Maryland</b> <b>30 April 1957</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/2/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Paradise Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>near Deer Park, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert C. Leighton</b>		24a. RECEIVED BY REGISTRAR DATE <b>5/2/57</b> 24b. REGISTRAR'S SIGNATURE <b>Julia Mowen</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate is to be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be retained by the funeral director.

RECEIVED

MAY 10 1957

BUREAU V. S.

04106

4998

## CERTIFICATE OF DEATH

Reg. Dist. No. 178

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>GARRETT</u>		STATE <u>MARYLAND</u>		COUNTY <u>GARRETT</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>RURAL- VINDEX</u>		LENGTH OF STAY (In this place) <u>8 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Vindex</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>West Vindex</u>		STREET ADDRESS (If rural give location) <u>West Vindex</u>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>SANDRA DARLENE STEWART</u>				<u>APRIL 5, 1957</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify)	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>Feb. 9, 1949</u>	<u>8</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Student</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>2nd. Grade</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>West Vindex, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>WILLIAM ALBERT STEWART</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MARCELLA KATHERN BROWN</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, No, or unk) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Star Route WM.A. STEWART, Kitzmiller, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Cardio-Vascular Renal Disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>with nodal edema</u>						<u>6 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Hepatitis</u>						<u>2 years</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Jan. 1954, to April 5, 1957, that I last saw the deceased alive on April 5, 1957, and that death occurred at 6:10 AM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Ralph Culbertson</u>		<b>M.D.</b> <u>Kitz Miller</u>		<b>ADDRESS</b> (Street, city, town, state) <u>Md. April 8-57</u>		<b>DATE SIGNED</b>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>4/8/57</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>I.O.O.F. Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Elk Garden, W.Va.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Arthur W. ...</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John F. Shapkins</u>		<b>ADDRESS</b> <u>Blaine, W.Va.</u>	
<b>DATE</b> <u>4/8/57</u>							

**INSTRUCTIONS**

**1** hours after death.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

BUREAU V. 1

APR 16 1957

RECEIVED

4099

## CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>7 SECOND STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>A.</b> Last <b>STUCK</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>10</b> Year <b>19 57</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/29/1888</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR: Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>POINT OF ROCKS, MD.,</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE BROWN</b>		14. MOTHER'S MAIDEN NAME <b>ADALINE WRIGHT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>MR. GEORGE STUCK, 7 SECOND STREET—OAKLAND, MD.,</b>	
17. <b>DECEASED</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Diabetes Mellitus</b> DUE TO <b>Diabetes Mellitus</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>10 yrs</b> <b>10 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>app.</b> , 19 <b>50</b> , to <b>April 10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>April 11</b> , 19 <b>57</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andrew E. Mance</b>		ADDRESS (Street, city or town, state) <b>Oakland Md</b>	
PHYSICIAN'S NAME (Type) <b>ANDREW E. MANCE, M.D.,</b>		DATE SIGNED <b>11 Apr 57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>APRIL 10, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>POINT OF ROCK</b>		22d. LOCATION (City, town, or county) (State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BOLDEN FUNERAL HOME</b>		24a. REC'D BY REGISTRAR <b>4/12/57</b>	
ADDRESS <b>OAKLAND, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>John C. Brown</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 11 1917

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04108

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>GARRETT</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAR GRANTSVILLE</u> c. LENGTH OF STAY IN 1b <u>—</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAR GRANTSVILLE</u> d. STREET ADDRESS <u>—</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>LARRY MARVIN WARNICK</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>APRIL 29 1957</u> Month Day Year							
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>OCT. 28 1952</u>		<b>9. AGE</b> (In years last birthday) <u>4</u> yrs. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> IF UNDER 24 HRS.: Hours <u>—</u> Min. <u>—</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>NONE</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MEYERSDALE COMM HOSP</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>MARVIN WARNICK</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY JORST</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>—</u>				<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service) <u>—</u>		<b>17. INFORMANT</b> <u>Marvin Warnick, Grantsville, Md</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRUSHING INJURY LEFT OCCIPITAL PORTION OF SKULL</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Heel of car ran over by right front wheel</u>							
<b>20c. TIME OF INJURY</b> Hour <u>3</u> a.m. <u>4/29</u> 1957 p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Farm near Grantsville Garrett Md</u>		<b>20f. (City or town)</b> <u>Grantsville</u>		<b>20g. (County)</b> <u>Garrett</u>		<b>20h. (State)</b> <u>Md</u>	
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <u>E. J. Baumgartner</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>							
<b>EXAMINER'S NAME (Type)</b> <u>E. J. BAUMGARTNER M.D.</u>				<b>DATE</b> <u>4/29/57</u>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>MAY 1, 1957</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>METHODIST CEM</u>			<b>22d. LOCATION (City, town, or county)</b> <u>NEW GERMANY-GARRETT CO MD</u>			<b>22e. (State)</b> <u>Md</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Donald J. Newman, Grantsville, Md</u>						<b>24a. REC'D BY REGISTRAR</b> <u>—</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>—</u>			

THIS DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

7 6 1957

RECEIVED

4101

## CERTIFICATE OF DEATH

Reg. Dist. No.

04109

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>GRANT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BAYARD 85x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>A.</b> Last <b>WILLIAMS</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>15</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/1/82</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COAL MINER Retired Soft COAL</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND, U.S.A.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>ANDREW WILLIAMS</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA FREELAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>232-03-2228</b>	
17. INFORMANT <b>Mrs. Iela Williams</b>		Address <b>Ba yard, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>177x Carcinomatosis</b> DUE TO (b) <b>Carcinoma Prostate</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>2 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 8, 1956</b> , to <b>April 15, 1957</b> , that I last saw the deceased alive on <b>April 14, 1957</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph Alvarez</b> M.D.		ADDRESS (Street, city or town, state) <b>Oakland, Maryland</b> DATE SIGNED <b>4/16/57</b>	
PHYSICIAN'S NAME (Type) <b>JOSEPH ALVAREZ M.D.</b>		<b>OAKLAND, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/17/1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bayard rd Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bayard, Grant Co., W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert C. Roughton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. RECEIVED BY REGISTRAR <b>4/17/57</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4102 CERTIFICATE OF DEATH

Reg. Dist. No.

04118

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN b <b>6 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ACCIDENT</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>WILHELM</b> Last <b>ZINKAN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>14</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/31/77</b>
9. AGE (In years last birthday) <b>80</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Accident, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY ZINKAN</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN MILLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. <b>Waldo Zinkan, Accident, Maryland</b>	
17. INFORMANT <b>Waldo Zinkan, Accident, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 9</b> , 19 <b>54</b> , to <b>Apr 14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>APRIL 14</b> , 19 <b>57</b> , and that death occurred at <b>5:55 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. I. Baumgartner</b> M.D. <b>3520 d St</b>		ADDRESS (Street, city or town, state) <b>OAKLAND, MARYLAND</b> DATE SIGNED <b>4/15/57</b>	
PHYSICIAN'S NAME (Type) <b>E. I. BAUMGARTNER, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/17/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St Paul's</b>	22d. LOCATION (City, town, or county) (State) <b>Accident, Garrett Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donald Newman</b>		ADDRESS <b>Grantsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>4/16/57</b>		24b. REGISTRAR'S SIGNATURE <b>John C. Howan</b>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. S.

APR 18 1957

RECEIVED